September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Deceased Individuals
Authorization for Release of Medical Records

Instructions for Personal Representative - Please list all doctors and health care providers who were involved in diagnosing and treating the Decedent's injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Please copy this exhibit and complete if you need to list more than one health care provider or other entities. Then, please print your name and address and sign in the block in Section 2.

When you sign this document, you give permission to the Decedent's doctors, health care providers or other entities listed below to disclose the Decedent's health information to the September 11th Victim Compensation Fund (VCF), the United States Department of Justice (DOJ), and the World Trade Center (WTC) Health Program administered by the National Institute for Occupational Safety and Health (NIOSH)[1] for purposes of evaluating your claim for compensation to the VCF. By signing this document, you also give permission to the VCF to disclose the Decedent's health information to the WTC Health Program and to the WTC Health Program to disclose the Decedent's health information to the VCF for the purpose of evaluating your claim for compensation under the VCF.

Please note that you may revoke this Authorization at any time, except to the extent that VCF, WTC Health Program, or the providers listed below have already acted based on this Authorization. To revoke this authorization, you must write to the providers or entities listed below and to the VCF at the address at the bottom of page 3 of this form.[2] This authorization is valid for six (6) years from the date signed or upon your written termination, whichever is sooner.

The Decedent's providers and certain other entities are required by the Privacy Rule under HIPAA to protect the Decedent's health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF and DOJ will continue to protect the confidentiality of the Decedent's medical records to the extent they are permitted to do so under another Federal law, the Privacy Act.[3] The VCF will not disclose the Decedent's identifiable health information that it receives under this Authorization without your written consent except where authorized to do so by law.

Information to be disclosed by the Decedent's health care providers (or other entities listed below) to the Victim Compensation Fund includes, but is not limited to, application or enrollment information, eligibility information, claims records, claim status, pension records and files, entire patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to the Decedent's doctors and medical care providers by other health care providers. The Decedent's health care providers and/or the VCF may also disclose this information to the WTC Health Program for the purpose of evaluating your claim for benefits under the VCF. In addition, the WTC Health Program may disclose information to the VCF for purposes of evaluating the Decedent's VCF claim.

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[1] For the purposes of this document, all references to the WTC Health Program also include NIOSH to the extent it administers the WTC Health Program, as well as all contractors and business associates of NIOSH who conduct activities on behalf of the WTC Health Program, including but not limited to the Clinical Centers of Excellence and Nationwide Provider Network.

[2] If you wish to revoke this authorization because you do not want the VCF and WTC Health Program to exchange the Decedent's health information for purposes of evaluating your claim for compensation under the VCF, then you only need to write to the VCF.

[3] The WTC Health Program will protect the Decedent's health information pursuant to HIPAA and/or any other relevant laws and regulations.

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Deceased Individuals
Authorization for Release of Medical Records

The Decedent's health care providers and/or the VCF may also disclose this information to the WTC Health Program for the purpose of evaluating your claim for benefits under the VCF. In addition, the WTC Health Program may disclose information to the VCF for purposes of evaluating your VCF claim. This information includes, but is not limited to, whether the Decedent was a member of the WTC Health Program, and if so, eligibility and enrollment information; where the Decedent received his/her WTC Health Program health care benefits; whether the Decedent has been certified for treatment under the WTC Health Program; the number of and specific conditions for which the Decedent has been certified for treatment under the WTC Health Program; and information relating to payment of claims for treatment and pharmaceuticals received under the WTC Health Program.

Disclosure requested will include otherwise confidential information. If records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information made available to the VCF.

I understand that this authorization is voluntary. However, if you refuse to sign this authorization, the VCF will not be able to process your claim for compensation.

By initialing, I acknowledge that the information described above may include mental health information and I authorize the release of such information. Initial here:

I hereby authorize the person, carrier or other entity listed below to disclose confidential information about the Decedent listed below to the VCF, the DOJ and NIOSH:

Section 1 - Name, telephone number and email address for doctors, health care providers or other entities.

Physician/Other Entity or Program:

Doctor/Provider/Entity Name

Doctor/Provider/Entity Address

Doctor/Provider/Entity Address continued

Suite Number

City

State/Province

Zip/Postal Code

( ) -

Telephone Number

Email Address

September 11th
Victim Compensation Fund

OMB 1105-0092

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Deceased Individuals
Authorization for Release of Medical Records

Section 2. - Decedent information

Decedent's Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Decedent's Social Security or National ID Number

Decedent's Date of Birth (mm/dd/yyyy)

Section 3. - Personal Representative Information and Signature

This information shall be sent to:

September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

I Certify that I am the person named below (Personal Representative making a claim to the Victim Compensation Fund on behalf of the Decedent) and I authorize the release of information listed above. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

Personal Representative Signature

Date (mm/dd/yyyy)

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit A to the Eligibility Form For Deceased Individuals
Authorization for Release of Medical Records

Section 3. - Personal Representative Information and Signature (continued)

Personal Representative's Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Social Security or National ID Number

Date of Birth (mm/dd/yyyy)

Type of coverage to which this authorization applies (the doctor, health care provider or other entity will indicate all that apply)

- ◯ Medical
- ◯ Disability
- ◯ Pharmacy
- ◯ Long Term Care
- ◯ Other. Please specify/describe.

OMB 1105-0092

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Deceased Individuals
Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that pension and health information be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to my health provider, pension fund or other entitiy listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE OR PENSION INFORMATION WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Deceased Individuals
Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

7. Name and address of health provider, pension fund, or other entity to release this information: Please indicate all.

- [●] New York Office of Payroll Administration (OPA)
  Room 200N
  One Centre Street
  New York, NY 10007
- [○] New York City Police Pension Fund (POLICE)
  233 Broadway, 19th Floor
  New York, NY 10279
- [○] New York Fire Department Pension Fund (FIRE)
  9 MetroTech Center
  Brooklyn, NY 11201
- [○] New York City Employees' Retirement System (NYCERS)
  335 Adams Street, Suite 2300
  Brooklyn, NY 11201-3724
- [○] Teachers' Retirement System of the City of New York (TRS)
  55 Water Street
  New York, NY 10041
- [○] New York City Board of Education Retirement System (BERS)
  65 Court Street, 16th Floor
  Brooklyn, NY 11201-4965

8. Name and address of person(s) or category of person to whom this information will be sent:

September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

Overnight deliveries can be made to:

September 11th Victim Compensation Fund
Claims Processing Center
1100 L Street N.W. - Suite 3000
Washington, DC 20005

OMB 1105-0092

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B1 to the Eligibility Form For Deceased Individuals
Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

Authorization for Release of Pension and Health Information from HIPAA and Non-HIPAA Entities

9(a). Specific information to be released:

● Complete Pension File, including, but not limited to: Information regarding the type of pension awarded (ADR, ODR or service), the amount, and whether or not the benefit was awarded pursuant to the WTC Disability Law.

Include: (*Indicate by Initialing*)

☐ Alcohol/Drug Treatment

☐ Mental Health Information

☐ HIV Related Information

Authorization to Discuss Health or Pension Information

9(b). ● By initialing here ☐, I authorize
(Initials)

The individuals and entities identified in Question #7
(Name of individual health care provider, pension fund or other entity)

to discuss my health or pension-related information with my attorney, or a governmental agency, listed here:

September 11th Victim Compensation Fund and the United States Department of Justice
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

○ At request of individual

● Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund

11. Date or event on which this authorization will expire:

Six (6) years from the date of signature or upon my written termination

12. If not the claimant, name of person signing form:

13. Authority to sign on behalf of claimant:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date:

Signature of claimant or representative authorized by law

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OMB 1105-0092

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B2 to the Eligibility Form For Deceased Individuals
Authorization for Release of Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B2 to the Eligibility Form For Deceased Individuals
Authorization for Release of Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

7. Name and address of health provider or other entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

Overnight deliveries can be made to:
September 11th Victim Compensation Fund
Claims Processing Center
1100 L Street N.W. - Suite 3000
Washington, DC 20005

OMB 1105-0092

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit B2 to the Eligibility Form For Deceased Individuals
Authorization for Release of Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

9(a). Specific information to be released:

○ Medical Record from (insert date) _____ to insert (date) _____

● Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

○ Other: _____

_____

Include: (*Indicate by Initialing*)

☐ Alcohol/Drug Treatment

☐ Mental Health Information

☐ HIV Related Information

Authorization to Discuss Health Information

9(b). ○ By initialing here ☐ (Initials), I authorize

The individuals and entities identified in Question #7

(Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

the September 11th Victim Compensation Fund and the United States Department of Justice

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ● At request of individual ● Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund	**11.** Date or event on which this authorization will expire: Six (6) years from the date of signature or upon my written termination.
12. If not the patient, name of person signing form:	**13.** Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

September 11th Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit C to the Eligibility Form For Deceased Individuals
Attorney Certification of Compliance with Provision on Limitation on Attorney Fees (Section 104.81)

If the Personal Representative has been represented by an attorney for services rendered in connection with this claim, **Personal Representative's attorney must complete the following certification:**

I hereby certify that:

(1) The amount I have charged or will charge for the services I have rendered in connection with this claim, including expenses routinely incurred in the course of providing legal services, is not more than 10 percent of an award that might be paid on this claim; **AND**

(2) I have not charged nor will I charge for any expenses incurred in connection with this claim that are not routinely incurred in the course of providing legal services, unless the Special Master has approved such expenses; **AND**

(3) One of the following statements is true concerning a civil action brought by or on behalf of the Decedent for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal (excluding civil actions to recover collateral source obligations or against any person who is a knowing participant in any conspiracy to hijack or commit any terrorist act) that was commenced after December 22, 2003 in which a release of all claims in such action was tendered prior to January 2, 2011:

- ◯ I did not charge a legal fee in connection with a settlement of this Decedent's claim(s) in such an action; OR
- ◯ I charged a legal fee in connection with a settlement of this Decedent's claim(s) in such an action that was 10 percent or more of the aggregate amount of compensation awarded though such settlement, and I have not charged nor will I charge for any services rendered in connection with this claim with the VCF; OR
- ◯ I charged a legal fee in connection with a settlement of this Decedent's claim(s) in such an action that was less than 10 percent of the aggregate amount of compensation awarded though such settlement, and the amount I have charged or will charge for the services I have rendered in connection with this claim with the VCF does not exceed the difference between 10 percent of such aggregate amount and the total amount of all legal fees I charged for services rendered in connection with such settlement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this ____ day of _____, 201____.

Signature of Attorney _____

Attorney's Name

Attorney's Firm/Address

Attorney's Firm/Address continued

Suite

City

State

Zip/Postal code

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September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit D to the Eligibility Form For Deceased Individuals
Attorney Request for Approval For Charge of Non-Routine Expenses

If the Personal Representative is represented by an attorney and the attorney is seeking expenses incurred in connection with the claim other than those that are routinely incurred in the course of providing legal services ("non-routine expenses"), the attorney must request the approval of such expenses by the Special Master. The Special Master will review such requests on a case-by-case basis.

○ Indicate here if you are seeking non-routine expenses in connection with this claim and attach a statement explaining the expenses for which you seek approval and why they should be approved.

Signature of Attorney

Date (mm/dd/yyyy)

Attorney's Name

Attorney's Firm/Address

Attorney's Firm/Address continued

Suite

City

State

Zip/Postal code

September 11th Victim Compensation Fund
Exhibit E to Eligibility Form For Deceased Individuals
Notice of Filing Claim

Instructions to Decedent's Personal Representative:

- Fill out a separate copy of this page for each person to whom you are required to provide a Notice of Filing.
- On each copy, fill out the name and address of the person to whom you are providing the Notice and insert the name of the Decedent in the spaces provided below as indicated.
- Deliver each Notice personally or by certified mail, return receipt requested.
- *You must deliver a copy of this document to the following people:*
  - The immediate family of the Decedent (including, but not limited to, the spouse, former spouse(s), children other dependents, siblings, and parents)
  - The Executor or Administrator and beneficiaries of the Decedent's will and life insurance policies.
  - Any other person who may reasonably be expected to assert an interest in an award or to have a cause or action to recover damages relating to the wrongful death of the Decedent.

TO: NAME: _____

ADDRESS: _____

_____

_____

You are receiving this notice to inform you that a claim on behalf of _____ (insert name of Decedent) is being filed with the September 11th Victim Compensation Fund of 2001. The claim is being filed by _____ (insert name of Personal Representative).

The rules that govern the Victim Compensation Fund state that only one claim may be filed in connection with the death of a Decedent and that the claim must be filed by the Decedent's Personal Representative. The rules also state that any award from the Victim Compensation Fund shall be paid to the Personal Representative and that the Personal Representative is required to distribute the award among the Decedent's beneficiaries in accordance with the laws of the Decedent's domicile.

You have been notified that a claim is being filed on behalf of _____ (insert name of Decedent) because the Personal Representative is required to give notice of claim filing to the Decedent's immediate family, to the Executor, Administrator, and beneficiaries of the Decedent's will and life insurance policies and to other people who might reasonably have an interest in any award that may be made from the Victim Compensation Fund.

The rules that govern the filing of claims with the Victim Compensation Fund require the Personal Representative waive any right to file a lawsuit for damages sustained as a result of the terrorist-related aircraft crashes on September 11, 2001 or debris removal. This waiver could affect the rights of others, including you, to file any such lawsuits.

You are not required to take any action in response to this notice. However, any objection to the filing of the claim must be made within 30 days after the claim has been filed, which could be as soon as 30 days from the date this notice was mailed or otherwise provided to you.

If you want to learn more about the Victim Compensation Fund, please call 1-855-885-1555; TDD:1-855-885-1558; outside the U.S.: 1-202-353-0356. Information can also be obtained over the internet at www.vcf.gov

September 11th Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

September 11th Victim Compensation Fund
Exhibit F - List of Individuals Notified of Claim Filing

I hereby certify that I have provided the required Notice of Filing of Claim to all the individuals listed below by either personal delivery or certified mail, return receipt requested, and that I am not aware of anyone else to whom such notice should be provided.

Signature of Personal Representative

Date (mm/dd/yyyy)

Relationship to Decedent

Mother:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

continued on next page

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

Father:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

Spouse:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

continued on next page

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

Former Spouse:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

Sibling:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

continued on next page

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

Sibling:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

Child:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

continued on next page

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

Child:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

Partner:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

continued on next page

September 11th
Victim Compensation Fund

Decedent's SSN or National ID Number

Personal Representative's SSN or National ID Number

Other: Please describe.

Last Name

First Name

Middle Name

Mailing Address

Mailing Address continued

Suite

City

State

Zip code

Date of Birth (mm/dd/yyyy)

Telephone Number

SSN or National ID Number (if available)

◯ Hand Delivered

Date of Delivery (mm/dd/yyyy)

◯ Certified Mail Return Receipt Requested

Date of Delivery (mm/dd/yyyy)

◯ Indicate here if you need more space for Exhibit F and are submitting additional pages.